Welcome to our practice!

We are excited at the prospect of meeting with you and your loved ones in order to provide you with certified specialist care in the fields of Oral & Maxillofacial Surgery, Dental Implantology, Prosthodontics, and Oral Pathology/Oral Medicine. Premier Oral & Facial Surgery is a modern, technologically-advanced, multi-specialty dental practice, with a unique philosophy, practical, and refreshing approach to patient care.

We are a relationships and referral-based practice, which means that our clients typically come to us referred by their family dentist, other dental specialists, and physicians who know us well enough to entrust us with the responsibility of providing specialty care for their patients. We are also honored to receive referrals from previous patients, their family members, and friends. We adhere to the strictest standards in order to provide high quality, personalized care, affordable, and long-term solutions for our clients. We are confident that your consultation visit with us will differentiate us from corporate offices with high doctor/staff turnover, those national chains that only offer limited "1 solution fits all" approaches, and those that use high-pressure tactics to sell treatment to patients.

Below you fill find information that will help you prepare for your first visit / consultation appointment.

Before Your First Visit / Consultation Appointment
Prior to your appointment we encourage you to complete and sign the Registration / First Visit forms, completing them as accurately as possible so we may better serve your needs.

At Your First Visit /Consultation Appointment
If you have a friend or family member that is able to come with you, please invite them to accompany you to your appointment. Please be sure to bring your photo ID, insurance card/information if you have dental insurance, and any other important information/materials such as photos, other records, models, or previous dentures, etc.

You will be welcomed by our friendly staff and taken for a panoramic radiograph which will serve as part of your initial examination. Our staff will then review your health history, record your blood-pressure, gather any additional information, and ensure your comfort. Next, one or more of our specialist doctors will then spend time with you to first discuss your dental issues, concerns, and treatment goals. Our doctors are especially good at taking the time to listen carefully to you. We will examine you and determine if study models or digital models of your teeth should be made. We may also take photographs. This will permit us to accurately diagnose your conditions, explain their findings in detail, and provide you with various treatment options.

By the end of your first visit, our team will work to ensure that you understand all of the recommended treatment options as well as the fees to complete your treatment. For some patients with complex needs, additional diagnostic appointments may be necessary prior to development of your treatment plan. Before we begin any treatment, you will be provided with a detailed written treatment plan that includes the exact costs for your treatment, an estimated treatment timeline, and provide information about available financing options.

Following Your First Visit / Consultation Appointment
Our team will be available to answer your questions, to coordinate your treatment with your referring dentist or physician, assist in financing applications, and to schedule your treatment once you are ready to proceed.

Sincerely,

Andonis Terezides, DDS
Oral & Maxillofacial Surgeon

Veneuska Ocando, DDS
Prosthodontist

Sarah Fitzpatrick, DDS
Oral Pathologist

PREMIER ORAL & FACIAL SURGERY

Center for Oral, Facial, Cosmetic Reconstruction
Center for Digital Implant & Smile Rehabilitation
Center for Oral Pathology & Oral Medicine

Date ____/____/____

Patient's Name _____ (Last / First / Middle) Age _____ Date of Birth ____/____/____

Patient's SS# ____-____-____ Sex ____Male ____Female Height ____ft ____in Weight ____lbs ____kg

Patient's Address _____ City _____ County _____ State _____ Zip _____

Home Phone # (____) ____-____ Business Phone # (____) ____-____ Cell # (____) ____-____

Patient's Employer _____ Business Address _____ Patient's Occupation _____

Person whom we can contact in case of emergency: _____ **Phone # (____) ____-____**

Who is your Family Physician _____ Address _____ Phone # (____) ____-____

Who is your Family Dentist _____ Address _____ Phone # (____) ____-____

Referred by _____ Address _____ Phone # (____) ____-____

If under age 18, who is responsible for paying your account? (Guarantor) ( ) Self ( ) Spouse ( ) Father ( ) Mother ( ) Other _____

Guarantor's Name _____ (Last / First / Middle) SS# ____-____-____

Guarantor's Address _____ City _____ County _____ State _____ Zip _____

Phone # (____) ____-____ Cell# (____) ____-____ Date of Birth ____/____/____ Sex ____Male ____Female

Marital Status:( ) Single ( ) Married: Spouse's Name _____ (Last / First / Middle) ( ) Widowed ( ) Divorced

Employer _____ Address _____ Phone # (____) ____-____

Guarantor's Occupation _____ ( ) Full Time ( ) Part Time ( ) Retired

---

INSURANCE INFORMATION

PATIENT: Student: ( ) Full Time ( ) Part Time ( ) Not School Name/City/State _____

( ) Single ( ) Married ( ) Widowed ( ) Divorced ( ) Legally Separated _____

Employed: ( ) Full Time ( ) Part Time ( ) Retired ( ) Not Do you belong to a PPO or HMO? ( ) Yes ( ) No

---

DENTAL INSURANCE COMPANY

Name _____

Address _____

_____

Phone # (____) ____-____

Group # _____ Group Name _____

_____

POLICY HOLDER

Name _____

Your relation to insured: ( ) Self ( ) Spouse ( ) Child ( ) Other

Gender: ( ) Male ( ) Female Date of Birth ____/____/____

Street _____

City _____ State _____ Zip _____

Phone # (____) ____-____

SS# ____-____-____ ID# _____

MEDICAL INSURANCE COMPANY

Name _____

Address _____

_____

Phone # (____) ____-____

Group # _____ Group Name _____

_____

POLICY HOLDER

Name _____

Your relation to insured: ( ) Self ( ) Spouse ( ) Child ( ) Other

Gender: ( ) Male ( ) Female Date of Birth ____/____/____

Street _____

City _____ State _____ Zip _____

Phone # (____) ____-____

SS# ____-____-____ ID# _____

****** Our doctors are not contracted to participate as "in-network" providers for any dental or medical insurance plans, or with Medicare and/or Medicaid. This permits us to take an honest and unbiased approach to your care in order to offer you our best services. This also does not mean that we are more expensive than other practices. In fact, this means we are usually able to provide the highest standards of care for all of our patients, EQUALLY, for the same fair price rather than charging patients differently for the exact same procedure(s).***

Most insruance plans permit you to see the doctor of your choice even if they are not "in-network". We will gladly fill out/complete your dental insurance claim form so you may mail it in to your insurance company. They will usually respond with any eligible reimbursement checks mailed directly to you within 4-8 weeks time.

It is our goal and intention for you to not be surprised by any hidden fees or surprise fees to complete your treatment. Before any treatment is performed, we will provide you with a detailed written treatment plan that includes the exact costs for your treatment, an estimated treatment timeline, and provide information about financing options.

Payment is expected at the time of service. We accept cash and all major credit cards. Personal checks are not accepted. If extended payments are required, financing options are available.***

HEALTH HISTORY FORM

Please describe your main symptom or problem (reason for today's visit): _____

_____

Date of last physical ? _____ Are you now, or have you been in the last five years, under the care of a physician for a specific problem? ( )Yes ( ) No

If yes, describe _____

Have you ever had or do you currently have any of the following? Please check those that apply. Elaborate further below if necessary:

- ☐ Anxiety
- ☐ Adrenal Disease
- ☐ AIDS/HIV +
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints/Replacement Joints
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bipolar Disorder
- ☐ Blood Disease (Hemophelia, Bleeding Disorder)
- ☐ Blood Clot (DVT, Pulmonary Embolism)
- ☐ Blood Transfusion
- ☐ Bone Cancer
- ☐ Breast Cancer
- ☐ Bronchitis
- ☐ Bruising (easy bruising)
- ☐ Cancer: (Specify- _____)
- ☐ Cardiac Stents
- ☐ Cataracts
- ☐ Chest Pain
- ☐ Chemotherapy
- ☐ Cholesterol Problem
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Bypass Grafts
- ☐ Coughing (Severe, Acute, Chronic)
- ☐ COPD
- ☐ CPAP or BIPAP Machine Use
- ☐ Depression
- ☐ Diabetes (Type 1 or Type 2)
- ☐ Dialysis
- ☐ Dizziness
- ☐ Eating Disorder (Anorexia, Bulimia, Other)
- ☐ Emphysema
- ☐ Epilepsy (Seizure Disorder, Convulsions)
- ☐ Excessive Bleeding
- ☐ Facial Trauma / Facial Fracture
- ☐ Fainting
- ☐ Fibromyalgia
- ☐ Glaucoma
- ☐ Genetic Disorder
- ☐ GI Problems (IBS, Chrons Disease, Colitis)
- ☐ Gout
- ☐ Graves Disease
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injury
- ☐ Heart Attack
- ☐ Heart Disease / Heart Failure
- ☐ Heart Murmur (Mitral Valve Proplapse, etc)
- ☐ Heart Valve Repair
- ☐ Heart Valve Replacement
- ☐ Hepatitis (A, B, C, D)
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease (Jaundice, Hepatitis, Cirrhosis)
- ☐ Leukemia / Lymphoma
- ☐ Low Blood Pressure
- ☐ Lupus
- ☐ Lung Cancer
- ☐ Mental Disorders
- ☐ Metastatic Cancer
- ☐ Multiple Myeloma
- ☐ Multiple Sclerosis
- ☐ Nervous Disorders
- ☐ Neuropathy
- ☐ Osteopenia / Osteoporosis
- ☐ Open Heart Surgery
- ☐ Oral Cancer / Head & Neck Cancer
- ☐ Pacemaker or Implanted Defibrillator
- ☐ Parkinson's Disease
- ☐ Paralysis
- ☐ Pneumonia
- ☐ Prostate Cancer Therapy
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatoid Arthritis Salivary Gland Disease
- ☐ Salivary Gland Cancer
- ☐ Sarcoma
- ☐ Sarcoidosis
- ☐ Schizophrenia
- ☐ Seasonal Allergies
- ☐ Shortness of Breath
- ☐ Sickle-Cell Trait / Sickle-Cell Anemia
- ☐ Sinus Problems
- ☐ Sleep Apnea
- ☐ Skin Cancer
- ☐ Snoring
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Temporomandibular Joint Disorder (TMJ/TMD)
- ☐ Thyroid Problems
- ☐ Transplant (Kidney, Lung, Heart, Other)
- ☐ Tuberculosis
- ☐ Tumor/Malignancy
- ☐ Temporomandibular Joint Disorder (TMJ/TMD)
- ☐ Ulcers (Skin, Mouth, Stomach)
- ☐ Venereal Disease
- ☐ Visual Problems
- ☐ Weakness

Radiation Therapy for head/neck/oral cancer? If Yes,

Total Dose _____cGy No. of treatments _____

Over what time span? _____

Radiation therapy completed when? Month_____ Year _____

Do you smoke? _____ # packs per day for _____ years

If you don't smoke now, have you ever smoked? If yes,

packs per day _____ for _____ years

When did you quit? _____

PAST SURGICAL HISTORY

Please list your past surgeries (including oral surgery), starting with the most recent:

Date	Procedure	Anesthesia type (circle one)			Anesthesia Complications (check "none" if none)
_____	_____	General	Local	Sedation	( ) None _____
_____	_____	General	Local	Sedation	( ) None _____
_____	_____	General	Local	Sedation	( ) None _____
_____	_____	General	Local	Sedation	( ) None _____
_____	_____	General	Local	Sedation	( ) None _____

Others: _____

Is there any condition concerning your health about which the doctor should be told/made aware? ( ) Yes _____

_____

_____

FAMILY HISTORY

Do you have a family history of the following? If yes, please tell us which relative(s).

Yes	No		Relative(s)	Yes	No		Relative(s)
( )	( )	Anesthesia problems		( )	( )	Diabetes	
( )	( )	Malignant hyperthermia		( )	( )	Heart disease	
( )	( )	Cancer				Other:	

WOMEN

Are you:

Yes No

( ) ( ) **Pregnant**? If yes, est.delivery date? _____ /____/_____ If you might be pregnant, but are not sure, please check here: ( )

( ) ( ) **Nursing**? If yes, please know that anesthesia medicines are found in breast milk following an anesthetic and can sedate your child. You should use alternative methods for nourishment for you child for 48 hours after an anesthetic and should pump and discard your breast milk during that time.

( ) ( ) **Taking birth control pills**? If yes, antibiotics that we prescribe may alter the effectiveness of birth control pills, such that you can get pregnant while taking the antibiotic. This possibility will be in effect for the remainder of your menstrual cycle. You should consult with your physician / OB-GYN for assistance regarding additional methods of birth control.

Please sign your initials to indicate your understanding: _____

ALLERGIES

Are you allergic to or have you had a reaction to any of the following medicines or substances? If yes, describe the reaction.

Yes	No		Reaction	Yes	No		Reaction
( )	( )	Penicillin		( )	( )	Local Anesthetics ("Novocaine")	
( )	( )	Amoxicillin		( )	( )	Aspirin (ASA)	
( )	( )	Clindamycin (Cleocin)		( )	( )	Ibuprofen (Advil, Motrin)	
( )	( )	Cephalosporins (Keflex, Ceclor)		( )	( )	Acetominophen (Tylenol, APAP)	
( )	( )	Erythromycin		( )	( )	Narcotics	
( )	( )	Sulfa (Bactrim)		( )	( )	Codeine	
( )	( )	Other Antibiotic				**Other Allergies/Medications? List and describe:**	
( )	( )	Diazepam (Valium)		( )	( )		
( )	( )	Fentanyl (Sublimaze)		( )	( )		
( )	( )	Midazolam (Versed)		( )	( )	Nuts	
( )	( )	Methohexital (Brevital)		( )	( )	Pork	
( )	( )	Propofol (Diprivan)		( )	( )	Eggs	
( )	( )	Ketamine (Ketalar)		( )	( )	Latex / Rubber	
( )	( )	Thiopental (Pentothal)		( )	( )	Adhesive Tape	

Allergies other than drug allergies (please list and describe reaction): _____

MEDICATIONS

There are some specific medicines that we especially need to know if you are currently taking or have taken in the past:

Do you take **Anticoagulants / Blood thinners**? ( ) Yes ( ) No If yes, please circle which medicine:

Aggrenox (Dipyridamole) **Coumadin** (Warfarin) **Heparin** **Lovenox** (Enoxaparin) **Plavix** (Clopidogrel) **Pradaxa** (Dabigatran)

Do you take **aspirin**? ( ) Yes ( ) No How much and how often? _____ mg _____ Last dose _____

Do you take / have you ever taken an **oral bisphosphonate** medicine for **osteoporosis**? ( ) Yes ( ) No If yes, please circle which medicine(s):

Actonel (Risedronate) **Boniva** (Ibandronate) **Didronel** (Etidronate) **Fosamax** (Alendronate) **Skelid** (Tiludronate)

How often? _____ How long? _____Years _____Months Last Dose? _____

Do you take / have you ever taken an **intravenous bisphosphonate** medicine? ( ) Yes ( ) No If yes, please circle which medicine(s):

Aredia (Pamidronate) **Bonefos** (Clodronate) **Boniva** (Ibandronate) **Reclast** (Zolendronate) **Zometa** (Zolendronate)

How often? _____ How long? _____Years _____Months Last Dose? _____

Do you take / have you ever taken a subcutaneous injection Anti-resorptive medicine? ( ) Yes ( ) No If yes, please circle which medicine(s):

Prolia (Denosumab) **XGeva** (Denosumab) How often? _____How long?_____ Years_____ Months_____

Do you take / have you ever taken or been placed on any Biologics ( ) Yes ( ) No If yes, please circle which medicine:

Enbrel (Etanercept) **Humira** (Adalimumab) **Remicade** (Infliximab) **Cosentyx** (Secukinumab) **Xeljanj** (Tofacitinib)

How often? _____How long?_____ Years_____ Months_____ Last Dose? _____

MEDICATION LIST

Including those listed on the previous page, do you take any kind of medicine, drugs, diet supplements, herbal remedies, or pills? ( ) Yes ( ) No

If no, please write "None" on the table below.

If yes, please list on the table below. See examples at the top of the table. Please fill in all information.

From what pharmacy do you obtain your prescription medicines? _____ Telephone: (_____) _____-_____

Please list all the medicines you are taking and provide the following information (you can find this information on the bottle):

Name of Medicine	Date Started	Dose (mg)	Route (Oral / IV / Topical / Nasal)	Frequency / Directions on bottle	Reason for taking
Example ***Metoprolol / Lopressor***	**01/01/2017**	**25 mg**	**Oral**	**Twice a day**	**Hypertension (high BP)**

ADDITIONAL INFORMATION

_____

_____

_____

_____

_____

I certify that I fully read and understand English, and I understand the questions and statements on this medical history form, and I have answered them truthfully.

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible resulting from any errors or omissions that I have made in the completion of this form.

_____ _____/_____/_____

Patient Signature **Date**

_____ _____/_____/_____

Parent or Guardian (if minor or developmentally-delayed) or Language Interpreter Signature **Date**

_____ _____/_____/_____

Doctor Signature **Date**

PREMIER
ORAL & FACIAL SURGERY

Center for Oral, Facial Cosmetic, & Reconstructive Surgery
Center for Digital Implant & Smile Rehabilitation
Center for Oral Pathology & Oral Medicine

A Multi-Specialty Approach For Optimized Oral Health & Well-Being
Proudly Partnering With Your Trusted Family Dentist to Create Beautiful Lasting Smiles

CONSENT FOR DISCLOSURE OF HEALTH INFORMATION

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

The purpose of this consent: By signing this form, you will consent to the use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

You have the RIGHT TO REVOKE this consent at any time by giving us written notice of your revocation.

Please understand that revocation of this consent will not affect any action we took prior to the receipt of your written revocation, and that we may decline to treat you or continue treating you following revocation of this consent.

I have had full opportunity to read and consider the contents of this consent form. I understand that by signing this consent form, I am giving my consent to use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

PATIENT/REPRESENTATIVE NAME: _____

PATIENT/REPRESENTATIVE SIGNATURE: _____ **DATE:** _____

OFFICE REPRESENTATIVE SIGNATURE: _____ **DATE:** _____

PREMIER
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A Multi-Specialty Approach For Optimized Oral Health & Well-Being
Proudly Partnering With Your Trusted Family Dentist to Create Beautiful Lasting Smiles

CONSENT FOR DENTAL / FACIAL PHOTOGRAPHY & VIDEOGRAPHY

We believe photography and videography is important for many procedures because it facilitates communication between our specialist doctors, your referring doctors, and dental lab technicians. Photography and videography permits us to more carefully evaluate as well as re-evaluate your condition and treatment options. The photos and videos may be used in performing simulations of your treatment and will help you understand particular challenges, limitations, concerns, or alternative options in your treatment. Furthermore, the photography and videography also helps us perform quality control measures regarding your treatment as well as help document long-term follow-up care.

I, _____ (Patient / Parent/Legal Guardian), authorize the doctors and staff at Premier Oral & Facial Surgery, to take photographs and/or videos of my face, jaws, teeth, and prosthetics before, during, and after treatment.

I do not expect compensation, financial or otherwise, for the use of these photographs. I understand that I will not receive any payment or royalty from any party for the use of these photos or videos.

Refusal to consent to photographs and/or filming will in no way affect the dental or medical care I will receive from my doctors, but may make it much more difficult or impossible for a laboratory technician to match a shade or improve the cosmetic outcome of my dental prosthesis.

I also understand that these images will be carefully used in order to protect personal and sensitive information from individuals or organizations which are not entitled to, authorized, or do not need to have/know additional information or personal identifying information about me such as my name.

I consent to allow the photographs to be used for the following:

- Dental Treatment Records
- Facilitation of Communication with the Dental Laboratory or Surgical Guide Company
- Dental Research and/or professional publications such as journals or textbooks
- Professional Dental and Medical Education including seminars, lectures, courses, symposia, or webinars

Signature (Patient/Parent/Legal Guardian) _____

Date _____

I consent to allow the photographs to be used for the following:

- Marketing material, including websites and printed materials, patient education, and social media

☐ Check here if you do not want your full-face shot used for any of the above purposes

Signature (Patient / Parent/ Legal Guardian) _____

Date _____

Premier Oral & Facial Surgery, LLC

13571 Narcoossee Road, Orlando, FL 32832

FINANCIAL POLICY & INSURANCE INFORMATION

Thank you for selecting our office for your dental, oral surgery, prosthodontics, or oral pathology needs. We understand and appreciate your financial concerns. We believe our fees are commensurate with our levels of education, expertise, technology, the quality of materials we use, and the exceptional care we provide.

For your convenience, we have outlined the following guidelines and policies to keep our patient's experience pleasant and efficient.

DENTAL / MEDICAL INSURANCE, MEDICARE, MEDICAID

Our doctors are not contracted with any insurance carriers, Medicare, or Medicaid at this facility. This permits us to have an unbiased approach to your care in order to offer you or your loved-ones our honest opinions and best services. This also does not mean that we are more expensive than other practices that are contracted with insurance plans. In fact, this means that we are able to offer and provide the highest standard of care for all of our clients, EQUALLY, for same fair price, rather than having to charge differently for the exact same procedure(s). When doctors participate in insurance plans, they often find themselves limited in the services they can offer their patients and having to search for cheaper materials and labs in order to offset their costs because of poor reimbursement from insurance companies. When it comes to patient care, we do not believe in cutting corners, using cheaper materials, and using unknown/less-experienced/foreign dental labs in order to cut costs. Instead, we believe our moral, ethical, and professional obligations are directly to our patients; to provide them to the best of our abilities with only highest standards of care, using only the best materials, and partnering with experienced labs and trusted technicians. Our commitment to our patients means we will continue to remain independent from the biases, pressures, and unethical practices often imposed by insurance carriers.

OUT OF NETWORK BENEFITS

We would still like you to inform us if you have any dental insurance. Even though we are not in-network with any dental insurance plans, patients usually still have the right to receive their care with any out-of-network provider of their choice. We would be pleased to provide you with a completed claim form so you can mail it to your insurance carrier. This way we can try help you maximize any benefits that you may be entitled to. On the claims form, we will instruct your insurance company to send any eligible reimbursements directly to you. In the event they accidentally send us a check, we will have to first return it to them so they may correctly reissue the payment directly to you.

THE TRUTH ABOUT INSURANCE

Please understand that insurance (especially dental insurance) does not typically cover the entire cost of treatment, especially complex treatment requiring care to be provided by a dental specialist. Insurance plans are usually best used in your general dentist's office because they designed to cover annual exams, basic x-rays, dental hygiene procedures, and routine dental work (basic fillings/ restorative procedures, and some minor specialty procedures, etc).

The reality is that most plans only pay a percentage of a "usual or customary" fee that is arbitrarily calculated by the insurance company. Insurance plans also have exclusion criteria, exception clauses, and yearly maximum limits for dental benefits that they provide. A preauthorization or predetermination may sometimes be possible, a preauthorization or predetermination is NOT A GUARANTEE OF PAYMENT. In fact, an insurance company may still deny payment or even request a refund for payments they have already made. This means that a patient may still be held financially responsible for a substantial bill that was previously "pre-authorized" / "pre-approved." It is because of these questionable, far too frequent, and deceptive tactics employed by the insurance companies that we have elected to not participate in any formal/contractual agreements with insurance companies.

If you are 65 years of age (or older), Medicare is your primary medical insurance. Medicare and most medical insurances DO NOT typically cover almost any specialist-level dental care including dental extractions, dental implants, or associated procedures such as bone-grafting or dental implant prosthetics. As such, our doctors here at Premier Oral & Facial Surgery have also opted out of the Medicare System, so our office cannot submit any information or claims to Medicare.

FEES AND PAYMENT FOR SERVICES

It is our goal and intention for you to never be surprised by any hidden fees or surprise fees to complete your treatment. Before any treatment is performed, we will inform you of the costs. By providing you with a detailed written treatment plan you will know exactly what the costs are related to your care from start to finish.

Payment is required at the time of service. For your convenience, we accept cash and all major credit cards. Personal checks are not accepted. If extended payments are required, financing options are available.

We have specially trained staff members dedicated to assisting you with financial arrangements, financing options, and to assist in the initial completion of your insurance claims form so that you may send it to your dental insurance carrier. If your carrier elects to reimburse you for any of the care, they will do so according to their contractual agreement held between them and you/your employer. Typically, they will respond within 4-6 weeks.

If you have received consent to use someone else's CareCredit, and they will not be present when the transaction is made, please have the cardholder contact CareCredit to have you added as an authorized user prior to your appointment.

For **DEBIT CARDS** and **CREDIT CARDS**, we require a signed consent letter by the cardholder, cardholder's photo ID, with signature for comparison, as well as the card itself.

IF WE PROVIDE CONSULTATION, EXAMINATION, or DIAGNOSTIC SERVICES

Payment in full is required at the time of service and will be collected after the evaluation has been performed. Typical consultation costs range on average between $150-$500 depending on the extent of the consultation services required.

PRIOR TO SCHEDULING SURGERY OR EXTENSIVE PROCEDURES

Some operations and procedures we provide require significant expense on our part to fabricate custom surgical guides, prosthetic devices, or to obtain materials and supplies dedicated solely for your treatment. These materials, supplies, and prosthetics are custom ordered and dedicated solely on your behalf. They are not designed or intended for use with other patients and therefore cannot be simply returned to the vendor or manufacturer for refund. If we anticipate your procedure will require special materials, equipment, or lab-fabricated guides/prosthetics, we will require that a deposit be placed prior to scheduling your procedure or surgery. The required amount of this scheduling deposit will be determined based on the extent of your treatment plan. For less-involved procedures and treatments that are anticipated to be under $3000.00, a refundable scheduling deposit of $200.00 will be required. Payment in full for the remainder of the treatment plan balance will be required by the date of the procedure or surgery. In the event you postpone or delay your surgery, we will continue to hold that deposit until you are ready to proceed as previously planned. We will apply your deposit accordingly toward the overall costs of your treatment once you decide you are ready to proceed with treatment. In the event you do not wish to proceed with treatment, any remaining balance of funds from your deposit or procedure pre-payment (minus the non-refundable expenses incurred thus-far in preparation/anticipation of your treatment or for consultation / treatment services already rendered) will be returned to you within 45 days of receipt of written request for refund.

IF WE PROVIDE TREATMENT

Payment in full is required prior to the start of treatment or service.

CANCELLATION CHARGES & FEES

Your appointment has been reserved exclusively for you. Any changes in your appointment without sufficient notice, affects many other patients. We kindly ask for at least a **24 hours' notice** to be given in order to avoid a broken appointment fee. We reserve the right to charge $50.00 per thirty minutes of scheduled time for missed/failed appointments.

We reserve the right to charge $50.00 per thirty minutes of scheduled time for **consultations or procedures**. For **surgical appointments**, **72 hours notice** is required to reschedule or cancel to avoid forfeiting the $200 surgery deposit.

Fees for treatment are subject to change based on changes that may be necessary to your treatment plan because of a change in your health/medical/dental condition (e.g., if you crack a tooth that was not part of the original treatment plan and it now needs to be extracted and replaced with either a bridge or an implant, there will be additional associated fees to incorporate those new/additional procedures/services in to your overall treatment plan). Our treatment plan fees/estimates are valid for and will be honored for 3 months (90 days from the time they are given/offered).

In consideration of professional services rendered, or to be rendered, by signing this you hereby agree to be financially responsible for all charges (at the Doctor's usual and customary fees), and for any expense that the Doctor may incur in collecting these fees; including ATTORNEY'S FEES.

Please sign below acknowledging you have received, read, and understand our financial and insurance policies outlined above.

_____	_____	____/____/____
PRINTED NAME	SIGNATURE	Date